Value-Based Insurance Design (VBID) Task Force

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September 19, 2014

Overview

- Establishment and Charge of Task Force
- Task Force Members
- Review VBID definition
- Review of Public Comment
- Next Steps

Task Force Establishment

- 2012: Concerns raised about increased enrollment in high-deductible health plans and their effect on patient outcomes
- March 2013: Council discussed VBID strategy
  - University of Michigan VBID Center hired as consultant to provide recommendations on promoting VBID in Maryland
- October 2013: Consultants submitted final report; Council passed motion to establish Task Force
- December 2013: Council passed motion to accept charter

Task Force Charge

- "Develop and recommend specific policy options and clinical areas and services for VBID in the Maryland Health Benefits Exchange and self-insured employer insurance market."
- "The basic premise of VBID is to align patients' out-of-pocket costs, such as copays and premiums, with the value of health services."
- "By reducing barriers to high-value treatments through lower costs to patients – "carrots" -- and discouraging low-value treatments through higher costs to patients – "sticks"-- plans can achieve improved health outcomes at any level of health care expenditure."

Members and Staff

Members

- James Chesley, MD
- Larry Gross
- Nicolette Highsmith Vernick, MPA
- Edward Koza, MD
- Lindsay H. Lucas, MBA
- Roger Merrill, MD
- Lisa Ogorzalek, JD, MHA
- Anne Timmons, CEBP
- Brenda Wilson

DHMH Staff

- Laura Herrera, MD, MPH
- Mona Gahunia, OD
- Donald Shell, MD, MPH
- Sara Cherico-Hsii, MPH

VBID Definition: Opening Statement

- VBID plans are built on the principles of engaging your members in their health and well-being, and designing a benefit plan that
  1. Promotes wellness by emphasizing primary/preventive care;
  2. Lowers or removes financial barriers to essential, high-value clinical services; and
  3. Discourages the use of low-value health services and providers.
- VBID plans clearly communicate with their members and provide tools to allow members to use their health plan more effectively and efficiently.
- VBID benefits are structured to offer rewards and incentives to members for being well and using the health care system efficiently. They align patients' out-of-pocket costs, such as copayments, with the value of services.

Original VBID Definition

- In Maryland, plans must contain the following elements in order to be considered a baseline VBID plan:
  - At least three incentives to use high-value services. A high-value service is one that is accepted in the peer-reviewed literature as providing considerable clinical benefit, relative to the cost;
  - At least two incentives to promote wellness and health among members. Incentives may include promoting disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs; and
  - Targeting incentives and interventions to specific patient groups (e.g. those with chronic disease(s)).
- Recognizing that many VBID plans evolve over time and slowly incorporate different incentives and disincentives, plans that contain the following element will receive a higher rating or recognition in the Exchange:
  - At least one incentive to discourage low-value or unproven services. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.

Revised VBID Definition

- A VBID plan would require the following elements:
- Incentives
  - Incentives to use high-value services for at least three medical conditions. A high-value service is one that provides considerable clinical benefit, relative to the cost;
  - At least three health and wellness incentives available to all plan members. Incentives may include disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs (e.g. Million Hearts); and
- Disincentives
  - Disincentives to discourage low-value or unproven services for at least three medical conditions. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.
- All incentives and disincentives must be evidenced-based, supported by professional organizations, and affect a meaningful number of members when implemented.
- The mandated preventative benefits covered under the Affordable Care Act will not be considered high-value services.

Review of Public Comment

- Posted on August 11, 2014 to the DHMH main webpage and emailed to relevant stakeholders
- Comments due by September 12, 2014
- Received 10 comments:
  - 5 from health plans and health systems
  - 2 from consumer groups
  - 2 from lobbying firm and consulting group
  - 1 from a large employer

Review of Public Comment

- Major themes in the comments include :
  - Do not limit professional support to Choosing Wisely
  - Incentivize services over medical conditions
  - Invite consumer and safety-net stakeholders to participate on the VBID TF
  - Incentivize consumers to choose high quality plans/providers
  - Use available evidence to determine low and high value services
  - Educate members on their health and health plans, focusing on quality and cost-effectiveness
  - Query health plans to determine which VBID elements are currently available in Maryland

Next Steps

- Should we expand the Task Force?
- Reconvene the VBID Task Force in October 2014 to review and respond to the public comments
  - All responses will be posted online
- Share a revised definition in December with the Council and update on other activities
- What areas should the VBID Task Force focus on next?

Discussion